		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027870

Facility Name: ST AGNES MANOR INC.

Address: 60 EAST 18TH ST. (Number) CHICACO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

IDPA ID Number: 363192742001

Date of Initial License for Current Owners: 07/26/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) JEFFREY K. SINGER, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	52,428	3,143	5,865	61,436	8
9	SNF/PED					9
10	ICF	2,604			2,604	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	55,032	3,143	5,865	64,040	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.06%

D. How many bed-hold days during this year were paid by Public Aid?
273 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1/1/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5,816

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		35,967	434,303	470,270		470,270		470,270			1
2	Food Purchase		467,109		467,109	(53,363)	413,746	(228)	413,518			2
3	Housekeeping	26,753	61,686	437,489	525,928		525,928	(62)	525,866			3
4	Laundry		45,085	126,536	171,621		171,621		171,621			4
5	Heat and Other Utilities			218,800	218,800		218,800	2,215	221,015			5
6	Maintenance	76,832		290,244	367,076		367,076	(5,038)	362,038			6
7	Other (specify):*											7
8	TOTAL General Services	103,585	609,847	1,507,372	2,220,804	(53,363)	2,167,441	(3,113)	2,164,328			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,241,931	(15,057)	1,938,942	3,165,816		3,165,816	(3,127)	3,162,689			10
10a	Therapy	26,752		45,737	72,489		72,489	(299)	72,190			10a
11	Activities	127,965	14,004	2,491	144,460		144,460	(370)	144,090			11
12	Social Services	126,734		34,344	161,078		161,078	(312)	160,766			12
13	Nurse Aide Training											13
14	Program Transportation			259	259		259		259			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,523,382	(1,053)	2,021,773	3,544,102		3,544,102	(4,108)	3,539,994			16
	C. General Administration											
17	Administrative			660,000	660,000		660,000	(546,230)	113,770			17
18	Directors Fees											18
19	Professional Services			30,130	30,130		30,130	8,787	38,917			19
20	Dues, Fees, Subscriptions & Promotions			24,150	24,150		24,150	(5,483)	18,667			20
21	Clerical & General Office Expenses	46,132	59,697	138,143	243,972		243,972	181,286	425,258			21
22	Employee Benefits & Payroll Taxes			187,431	187,431	53,363	240,794	(3,102)	237,692			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,735	1,735		1,735	17	1,752			24
25	Other Admin. Staff Transportation			447	447		447	4,299	4,746			25
26	Insurance-Prop.Liab.Malpractice			132,459	132,459		132,459	4,586	137,045			26
27	Other (specify):*							42,934	42,934			27
28	TOTAL General Administration	46,132	59,697	1,174,495	1,280,324	53,363	1,333,687	(312,906)	1,020,781			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,673,099	668,491	4,703,640	7,045,230		7,045,230	(320,127)	6,725,103			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST AGNES MANOR INC. #0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			84,849	84,849		84,849	127,232	212,081			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,814	3,814		3,814	294,866	298,680			32
33	Real Estate Taxes			243,457	243,457		243,457	3,661	247,118			33
34	Rent-Facility & Grounds			485,324	485,324		485,324	(485,324)				34
35	Rent-Equipment & Vehicles			13,021	13,021		13,021		13,021			35
36	Other (specify):*											36
37	**TOTAL Ownership**			830,465	830,465		830,465	(59,565)	770,900			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	106,204	435,637	93,506	635,347		635,347	(112)	635,235			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			14,422	14,422		14,422	(1,131)	13,291			41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	106,204	435,637	215,785	757,626		757,626	(1,243)	756,383			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,779,303	1,104,128	5,749,890	8,633,321		8,633,321	(380,936)	8,252,385			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	116,574	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(228)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,700)	21		18
19	Entertainment				19
20	Contributions	(1,350)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,970)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,414)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(53,358)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 51,553		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(432,489)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (432,489)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (380,936)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

ST AGNES MANOR INC.

ID# 0027870

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	PPA - OFFICE EXPENSE	$ (554)	21	1
2	PPA - PAYROLL TAXES	(3,102)	22	2
3	PPA - RN SALARIES	(125)	10	3
4	PPA - LPN SALARIES	(202)	10	4
5	PPA - NURSE AIDE SALARIES	(2,791)	10	5
6	PPA - RESIDENT ASSISTANT SALARIES	(9)	10	6
7	PPA - RT SALARIES	(112)	39	7
8	PPA - PT AIDES SALARIES	(299)	10A	8
9	PPA - ACTIVITIES SALARIES	(370)	11	9
10	PPA - SOCIAL SERVICE SALARIES	(312)	12	10
11	PPA - MAINTENANCE SALARIS	(124)	06	11
12	PPA - HOUSEKEEPING SALARIES	(62)	03	12
13	PPA - ADMIN EMPLOYEE SALARIES	(1,147)	17	13
14	PPA - OFFICE SALARIES	(57)	21	14
15	PPA - SECURITY SALAIES	(70)	06	15
16	MISC INCOME	(547)	21	16
17	VENDING MACHINE INCOME	(1,131)	41	17
18	MISC EXPENSE	(221)	21	18
19	BANK CHARGES	(26,903)	21	19
20	NON-ALLOWABLE FEES	(485)	20	20
21	2003 SEMINAR EXPENSE	(150)	24	21
22	NON-ALLOWABLE AUTO	(447)	25	22
23	CAPITALIZED R&M	(12,131)	06	23
24	BLDG COMPANY PROFESSIONAL FEES	(2,007)	19	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
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92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(53,358)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(228)											(228)	2
3	Housekeeping	(62)											(62)	3
4	Laundry													4
5	Heat and Other Utilities			2,215									2,215	5
6	Maintenance	(12,325)		7,287									(5,038)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(12,615)		9,502									(3,113)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(3,127)											(3,127)	10
10a	Therapy	(299)											(299)	10a
11	Activities	(370)											(370)	11
12	Social Services	(312)											(312)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(4,108)											(4,108)	16
	C. General Administration													
17	Administrative	(1,147)		(660,000)	34,917	80,000							(546,230)	17
18	Directors Fees													18
19	Professional Services	(2,007)	2,007	8,787									8,787	19
20	Fees, Subscriptions & Promotions	(6,805)		1,322									(5,483)	20
21	Clerical & General Office Expenses	(33,396)		129,338		85,344							181,286	21
22	Employee Benefits & Payroll Taxes	(3,102)											(3,102)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(150)		167									17	24
25	Other Admin. Staff Transportation	(447)		4,746									4,299	25
26	Insurance-Prop.Liab.Malpractice			4,586									4,586	26
27	Other (specify):*			21,655	7,428	13,851							42,934	27
28	**TOTAL General Administration**	(47,054)	2,007	(489,399)	42,345	179,195							(312,906)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(63,777)	2,007	(479,897)	42,345	179,195							(320,127)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	116,574	5,493	5,165									127,232	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		267,954	26,912									294,866	32
33	Real Estate Taxes			3,661									3,661	33
34	Rent-Facility & Grounds		(485,324)										(485,324)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	116,574	(211,877)	35,738									(59,565)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(112)											(112)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(1,131)											(1,131)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(1,243)											(1,243)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	51,553	(209,870)	(444,159)	42,345	179,195							(380,936)	45

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DANIEL O'BRIEN	20.00%	SEE ATTACHED		SEE ATTACHED		
MARY O'BRIEN	20.00%					
PETER O'BRIEN	60.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 485,324	1721 CORPORATION	100.00%	$	$ (485,324)	1
2	V	32	INTEREST EXPENSE				267,954	267,954	2
3	V	30	DEPRECIATION				5,493	5,493	3
4	V	19	PROFESSIONAL FEES				2,007	2,007	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 485,324			$ 275,454	$ * (209,870)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 2,215	$ 2,215	15
16	V	6	REPAIRS AND MAINT.				7,287	7,287	16
17	V	19	PROFESSIONAL FEES				8,787	8,787	17
18	V	20	DUES AND SUBSCRIPTIONS				1,322	1,322	18
19	V	21	CLERICAL AND GENERAL				129,338	129,338	19
20	V	24	SEMINARS				167	167	20
21	V	25	AUTO EXPENSE				4,746	4,746	21
22	V	26	PROPERTY INSURANCE				4,586	4,586	22
23	V	27	GEN. ADMIN. - EMP. BEN.				21,655	21,655	23
24	V	30	DEPRECIATION				5,165	5,165	24
25	V	32	INTEREST				26,912	26,912	25
26	V	33	REAL ESTATE TAXES				3,661	3,661	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	660,000				(660,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 660,000			$ 215,841	$ * (444,159)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 6,250	$ 6,250	15
16	V	27	EMP. BEN.-D. O'BRIEN				3,140	3,140	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				16,667	16,667	18
19	V	27	EMP. BEN.-P. O'BRIEN				2,455	2,455	19
20	V								20
21	V	17	SALARY-C. STUMPF				12,000	12,000	21
22	V	27	EMP. BEN.-C. STUMPF				1,833	1,833	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 42,345	$ * 42,345	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				80,000	80,000	17
18	V	21	CLERICAL SALARY				85,344	85,344	18
19	V	27	GEN. ADMIN. - EMP. BEN.				13,851	13,851	19
20	V	30	DEPRECIATION-WAREHOUSE						20
21	V	33	REAL ESTATE TAXES						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 179,195	$ * 179,195	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 424,882	WINDY CITY NURSING	100.00%	$ 424,882	$	15
16	V	3	HOUSKEEPING	438,082			438,082		16
17	V	4	LAUNDRY	126,536			126,536		17
18	V	6	MAINTENANCE	183,831			183,831		18
19	V	12	SOCIAL SERVICES	29,870			29,870		19
20	V	21	OFFICE	112,572			112,572		20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 1,315,773			$ 1,315,773	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING SUPPLIES	$ 42,118	ST. AGNES MEDICAL EQUIPMENT	100.00%	$ 42,118	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 42,118			$ 42,118	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	ADMIN	20.00%	SEE ATTACHED	6	15.00%	Alloc.Salary	$ 6,250	17-7	1
2	PETER O'BRIEN	OWNER	ADMIN	60.00%	SEE ATTACHED	6	10.00%	Alloc.Salary	16,667	17-7	2
3	CHARLES STUMPF	RELATIVE	ADMIN	0	SEE ATTACHED	8	17.77%	Alloc.Salary	12,000	17-7	3
4	JAMES WEST	RELATIVE	CLERICAL	0	SEE ATTACHED	10.9	27.25%	Alloc.Salary	14,968	21-7	4
5	KATHLEEN STUMPF	RELATIVE	CLERICAL	0	SEE ATTACHED	5	11.11%				5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 49,885		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	235,319	5	$ 8,137	$	64,040	$ 2,215	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	235,319	5	26,777		64,040	7,287	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	235,319	5	32,288		64,040	8,787	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	235,319	5	4,856		64,040	1,322	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	235,319	5	475,262	393,151	64,040	129,338	5
6	24	SEMINARS	PATIENT DAYS	235,319	5	613		64,040	167	6
7	25	AUTO EXPENSE	PATIENT DAYS	235,319	5	17,441		64,040	4,746	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	235,319	5	16,851		64,040	4,586	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	235,319	5	79,574		64,040	21,655	9
10	30	DEPRECIATION	PATIENT DAYS	235,319	5	18,981		64,040	5,165	10
11	32	INTEREST	PATIENT DAYS	235,319	5	98,891		64,040	26,912	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	235,319	5	13,454		64,040	3,661	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 793,125	$ 393,151		$ 215,841	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	25,000	25,000	6	6,250	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	12,558		6	3,140	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	125,000	125,000	6	16,667	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	18,409		6	2,455	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	67,500	67,500	8	12,000	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	10,311		8	1,833	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 258,778	$ 217,500		$ 42,345	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	2,915				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1					2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	255,302	255,302		80,000	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		2	218,362	218,362		85,344	4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	68,636			13,851	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				6
7	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,857				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 548,154	$ 473,664		$ 179,195	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINDY CITY NURSING
Street Address: 1541 N. WELLS
City / State / Zip Code: CHICAGO, IL 60601
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOC			$	$		$ 424,882	1
2	3	HOUSEKEEPING	DIRECT ALLOC						438,082	2
3	4	LAUNDRY	DIRECT ALLOC						126,536	3
4	6	MAINTENANCE	DIRECT ALLOC						183,831	4
5	12	SOCIAL SERVICES	DIRECT ALLOC						29,870	5
6	21	OFFICE	DIRECT ALLOC						112,572	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,315,773	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ST. AGNES MEDICAL EQUIPMENT
Street Address: 1541 N WELLS
City / State / Zip Code: CHICAGO, IL 60601
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING SUPPLIES	DIRECT ALLOC			$	$		$ 42,118	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 42,118	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DANIEL O'BRIEN		X	WORKING CAPITAL				5,237,762				6
7	TIFCO		X	INSURANCE FINANCING							3,814	7
8												8
9	TOTAL Facility Related						$	$ 5,237,762			$ 3,814	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							2,924,252			294,866	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 2,924,252			$ 294,866	14
15	TOTALS (line 9+line14)						$	$ 8,162,014			$ 298,680	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	EXCHANGE BANK		X	WORKING CAPITAL			$	$ 8,000			$	1
2	BUILDING COMPANY	X		WORKING CAPITAL				2,916,252			267,954	2
3	ALLOC. MADO MGMT	X									26,912	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 2,924,252			$ 294,866	21

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		$ * 244,715	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 240,755	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,960)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 251,079	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 247,119	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	231,157	8
	1998	245,703	9
	1999	240,677	10
	2000	231,084	11
	2001	237,094	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

* SEE NOTE ATTACHED
ACCRUAL = 2001 TAX x 1.04
237094 x 1.04 = 247119
ALLOCATED FROM MADO MANAGEMENT = $3661

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST AGNES MANOR INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-22-301-014-0000	LONG TERM CARE PROPERTY	$ 10,274.82	$ 10,274.82
2.	17-22-301-015-0000	LONG TERM CARE PROPERTY	$ 29,576.89	$ 29,576.89
3.	17-22-301-016-0000	LONG TERM CARE PROPERTY	$ 124,937.77	$ 124,937.77
4.	17-22-301-017-0000	LONG TERM CARE PROPERTY	$ 60,125.06	$ 60,125.06
5.	17-22-301-050-0000	LONG TERM CARE PROPERTY	$ 12,179.28	$ 12,179.28
6.	17-04-204-012-0000	HOME OFFICE ALLOCATION	$ 13,454.36	$ 3,661.49
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 250,548.18	$ 240,755.31

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST AGNES MANOR INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	31,879		$ 75,250	1
2					2
3	TOTALS	31,879		$ 75,250	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1983	1983	$ 424,750	$	35	$	$	$ 424,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	1,400,995		20	70,150	70,150	1,306,065	9
10	Various			1984	132,601		20	6,630	6,630	125,396	10
11	Various			1986	21,150		20	-		21,150	11
12	Various			1987	10,000		20	500	500	9,336	12
13	Various			1989	72,045		20	3,603	3,603	40,700	13
14	Various			1990	150,700		20	7,329	7,329	77,613	14
15	Various			1991	37,665		20	1,883	1,883	18,737	15
16	Various			1992	45,688		20	2,285	2,285	16,035	16
17	Various			1993	56,127		20	2,806	2,806	21,787	17
18	Various			1994	133,605		20	6,681	6,681	49,831	18
19	Various			1995	110,000		20	10,200	10,200	75,019	19
20	Various			1996	192,259		20	9,744	9,744	62,712	20
21	Various			1997	244,818		20	13,243	13,243	73,083	21
22	Various			1998	312,914		20	15,649	15,649	71,258	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		87,027	2,921		3,195	274	52,807	68
69	Financial Statement Depreciation			63,501			(63,501)		69
70	TOTAL (lines 4 thru 69)		$ 3,432,344	$ 66,422		$ 153,898	$ 87,476	$ 2,446,279	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,432,344	$ 66,422		$ 153,898	$ 87,476	$ 2,446,279	1
2	ELEVATOR FRAMES	1999	545		20	27	27	81	2
3	REPAIR WORK	1999	1,000		20	50	50	150	3
4	LIGHTING SUPPLIES	1999	1,309		20	65	65	195	4
5	KRAFT INSULATION	1999	1,916		20	96	96	288	5
6	PLASTER BOARD	1999	2,440		20	122	122	366	6
7	PLASTER BOARD	1999	1,163		20	58	58	174	7
8	PANEL AT LAUNDRY RM	1999	1,102		20	55	55	165	8
9	LIGHTING SUPPLIES	1999	618		20	31	31	93	9
10	ELEVATOR REPAIRS	1999	553		20	28	28	84	10
11	LIGHTING SUPPLIES	1999	1,261		20	63	63	189	11
12	(8) 4SP MOTORS	1999	628		20	31	31	93	12
13	LOBBY LEVELING	1999	1,480		20	74	74	222	13
14	GENERATOR REPAIRS	1999	675		20	34	34	102	14
15	CONTROL BOARD	1999	1,861		20	93	93	279	15
16	MIX CEMENT	1999	4,650		20	233	233	699	16
17	ELECTRICAL SUPPLIES	1999	608		20	30	30	90	17
18	LANDSCAPING	1999	6,417		20	321	321	963	18
19	TOILET SUPPLIES	1999	822		20	41	41	123	19
20	HADN RAILINGS	1999	2,150		20	108	108	324	20
21	REPAIR CONTROL	1999	941		20	47	47	141	21
22	CHILLER	1999	850		20	43	43	129	22
23	TILES/ELECTRICAL	1999	719		20	36	36	108	23
24	CEILING MATERIALS	1999	885		20	44	44	132	24
25	REPAIR WALK-IN REFRI	1999	2,300		20	115	115	345	25
26	SWING DOORS	1999	944		20	47	47	141	26
27	METAL DOOR	1999	1,003		20	50	50	150	27
28	BIRCH PLYWOOD	1999	2,573		20	129	129	387	28
29	CTN 2X2 CHEYENE	1999	1,988		20	99	99	297	29
30	CONCRETE PAD	1999	900		20	45	45	135	30
31	LANDSCAPING	1999	1,125		20	56	56	168	31
32	TILES	1999	1,217		20	61	61	183	32
33	REPAIR WORK	1999	1,451		20	73	73	219	33
34	TOTAL (lines 1 thru 33)		$ 3,480,438	$ 66,422		$ 156,303	$ 89,881	$ 2,453,494	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,480,438	$ 66,422		$ 156,303	$ 89,881	$ 2,453,494	1
2	INSULATION	1999	1,500		20	75	75	225	2
3	CARPETING	1999	630		20	32	32	96	3
4	DOOR LOCKS	1999	629		20	31	31	93	4
5	REPAIR DOOR CHILLER	1999	2,900		20	145	145	435	5
6	REPAIR EXHAUSTION	1999	1,019		20	51	51	153	6
7	FAN COIL	1999	2,685		20	134	134	402	7
8	REMOVE FAN COILS	1999	6,520		20	326	326	978	8
9	WOOD PRODUCTS	1999	3,353		20	168	168	504	9
10	TILES CEILING	1999	1,234		20	62	62	186	10
11	ELECTRICAL SUPPLIES	1999	1,595		20	80	80	240	11
12	SCHLAGE LOCKS	1999	1,557		20	78	78	234	12
13	SCHLAGE LOCKS	1999	1,142		20	57	57	171	13
14	ELECTRICAL	1999	590		20	30	30	90	14
15	BLINDS	1999	2,352		20	118	118	354	15
16	PAINTS	1999	816		20	41	41	123	16
17	TILES/GROUT	1999	2,794		20	140	140	420	17
18	MACHINE RENTAL FOR C	1999	1,628		20	81	81	243	18
19	ELEVATOR REPAIRS	1999	1,448		20	72	72	216	19
20	SPRINKLER	1999	3,381		20	169	169	507	20
21	CHILLER	1999	2,235		20	112	112	336	21
22	CHILLER	1999	1,450		20	73	73	219	22
23	CALL SYSTEM	1999	1,030		20	52	52	156	23
24	METAL DOORS	1999	12,476		20	624	624	1,872	24
25	TILES/SLABS	1999	26,862		20	1,343	1,343	4,029	25
26	AC REPAIRS	1999	1,919		20	96	96	288	26
27	CHANDELEIR	1999	8,374		20	419	419	1,257	27
28	ELECTRICAL	1999	478		20	24	24	72	28
29	FIRE ALARM SYSTEM	1999	24,144		20	1,207	1,207	3,621	29
30	ADD'L ELECTRICAL	1999	18,700		20	935	935	2,805	30
31	SPRINKLER ADDITION	1999	3,105		20	155	155	465	31
32	ADD'L ELECTRICAL	1999	2,570		20	129	129	387	32
33	SPRINKLER ADDITION	1999	4,976		20	249	249	747	33
34	TOTAL (lines 1 thru 33)		$ 3,626,530	$ 66,422		$ 163,611	$ 97,189	$ 2,475,418	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,626,530	$ 66,422		$ 163,611	$ 97,189	$ 2,475,418	1
2	MACHINE RENTAL FOR C	1999	4,529		20	226	226	678	2
3	PLYWOOD	1999	3,491		20	175	175	525	3
4	WOOD TRIM	1999	3,639		20	182	182	546	4
5	WOOD TRIM	1999	573		20	29	29	87	5
6	DOORS	1999	856		20	43	43	129	6
7	OAK RAIL	1999	4,843		20	242	242	726	7
8	OAK RAIL	1999	3,418		20	171	171	513	8
9	ELECTRICAL	1999	2,500		20	125	125	375	9
10	WATER CHILLER	1999	29,315		20	1,466	1,466	4,398	10
11	AC UNIT	1999	1,650		20	83	83	249	11
12	ELECTRICAL	1999	3,516		20	176	176	528	12
13	GRANITE RECEPTION DE	1999	3,539		20	177	177	531	13
14	TILES/SLABS	1999	1,181		20	59	59	177	14
15	INSULATION	1999	1,500		20	75	75	225	15
16	REPAIR WORK	1999	1,500		20	75	75	225	16
17	GLASS & MIRROR	1999	1,160		20	58	58	174	17
18	HEATING & COOLING UN	1999	10,481		20	524	524	1,572	18
19	AC REPAIRS	1999	695		20	35	35	105	19
20	METAL DOORS	1999	1,975		20	99	99	297	20
21	BLINDS	1999	1,746		20	87	87	261	21
22	LIGHTING FIXTURES	1999	3,313		20	166	166	498	22
23	SPRINKLER	1999	3,408		20	170	170	510	23
24	SWING DOORS	1999	1,172		20	59	59	177	24
25	BLINDS	1999	266		20	13	13	39	25
26	BLINDS	1999	2,086		20	104	104	312	26
27	BLINDS	1999	4,146		20	207	207	621	27
28	ARCHITECT FEES	1999	3,369		20	168	168	504	28
29	ANNEX ADDITION	1999	93,480		20	4,674	4,674	14,022	29
30	FIRE EQUIPMENT	2000	17,038		20	852	852	1,775	30
31	WIRING	2000	1,600		20	80	80	167	31
32	SPRINKLER PROJECT	2000	3,381		20	169	169	352	32
33	FIXTURES	2000	767		20	38	38	79	33
34	TOTAL (lines 1 thru 33)		$ 3,842,663	$ 66,422		$ 174,418	$ 107,996	$ 2,506,795	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,842,663	$ 66,422		$ 174,418	$ 107,996	$ 2,506,795	1
2	FENCE	2000	550		20	28	28	58	2
3	FIRE PROOFING	2000	1,010		20	51	51	106	3
4	FIRE DETECTION SYSTM	2000	625		20	31	31	65	4
5	MASTER BOX	2000	1,090		20	55	55	115	5
6	ROOF REPAIRS	2000	22,260		20	1,113	1,113	2,319	6
7	SPRINKLER REPAIRS	2000	1,107		20	55	55	115	7
8	CONCRETE WORK	2000	2,450		20	123	123	256	8
9	BLINDS	2000	2,474		20	124	124	258	9
10	TEST HEADER	2000	5,656		20	283	283	590	10
11	MICROPROCESSOR	2000	3,890		20	195	195	406	11
12	BLOCK SEALER	2000	5,736		20	287	287	598	12
13	SHUTTERS	2001	2,656		20	133	133	233	13
14	SHUTTERS	2001	1,180		20	59	59	98	14
15	HANDRAILS	2001	1,665		20	83	83	145	15
16	ELEVATOR	2001	27,500		20	1,375	1,375	2,635	16
17	VERTICLE BLINDS	2001	2,150		20	108	108	216	17
18	TILE	2001	2,450		20	123	123	236	18
19	STEAM TABLE COVERS	2001	1,850		20	93	93	171	19
20	HEAT EXCHANGER	2001	1,740		20	87	87	160	20
21	ELECTRICAL	2001	1,150		20	58	58	102	21
22	DOOR SYSTEM	2001	5,485		20	274	274	457	22
23	VERTICLE BLINDS	2001	2,216		20	111	111	185	23
24	DOOR SYSTEM	2001	1,500		20	75	75	131	24
25	FIRE & SECURITY SYST	2001	5,165		20	258	258	409	25
26	FENCE & DRIVE GATE	2001	2,450		20	123	123	185	26
27	VERTICLE BLINDS	2001	3,281		20	164	164	232	27
28	DRIVE UNIT	2001	3,700		20	185	185	247	28
29	VERTICLE BLINDS	2001	1,875		20	94	94	118	29
30	ELECTRICAL	2001	16,320		20	816	816	1,020	30
31	HANDRAIL	2001	650		20	33	33	66	31
32	HOT WATER UNIT	2001	550		20	28	28	56	32
33	BURNER REPAIRS	2001	710		20	36	36	69	33
34	TOTAL (lines 1 thru 33)		$ 3,975,754	$ 66,422		$ 181,079	$ 114,657	$ 2,518,852	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,975,754	$ 66,422		$ 181,079	$ 114,657	$ 2,518,852	1
2	POWER VENTER	2001	795		20	40	40	77	2
3	CEILING TILES	2001	3,026		20	151	151	302	3
4	CEILING FAN	2001	696		20	35	35	64	4
5	CONCRETE WORK	2001	875		20	44	44	73	5
6	CEILING TILES	2001	666		20	33	33	61	6
7	LIGHT FIXTURES	2001	540		20	27	27	50	7
8	FENCE	2001	725		20	36	36	57	8
9	AC REPAIRS	2001	530		20	27	27	41	9
10	ROOF REPAIRS	2001	1,450		20	73	73	110	10
11	HEATER BOOSTER	2001	591		20	30	30	43	11
12	ROOF REPAIRS	2001	1,400		20	70	70	99	12
13	ELECTRICAL REPAIRS	2001	962		20	48	48	60	13
14	PIPE WORK	2001	1,375		20	69	69	92	14
15	LIGHT FIXTURES	2001	1,086		20	54	54	68	15
16	PUMP	2001	551		20	28	28	35	16
17	CEILING TILES	2001	1,160		20	58	58	73	17
18	MOTOR	2001	602		20	30	30	35	18
19	PAINTING	2001	676		20	34	34	40	19
20	CEILING TILES	2001	1,102		20	55	55	64	20
21	BATHROOM REMODEL	2001	2,737		20	137	137	194	21
22	VERTICAL BLINDS	2002	4,176		20	209	209	209	22
23	ELEVATOR MOTOR	2002	27,500		20	1,375	1,375	1,375	23
24	AIR CONDITIONER	2002	2,704		20	135	135	135	24
25	SMOKE DETECTOR ALARM REPAIRS	2002	796		20	40	40	40	25
26	WATER GALLON EXTINGUISHER REPAIRS	2002	623		20	31	31	31	26
27	REPAIR FIRE ALARM SYSTEMS	2002	646		20	32	32	32	27
28	DOOR CLOSER REPAIRS	2002	611		20	31	31	31	28
29	FIRE ALARM WIRING REPAIRS	2002	600		20	30	30	30	29
30	FIRE PUMPS	2002	1,520		20	76	76	76	30
31	WATER HEATER REPAIRS	2002	1,830		20	92	92	92	31
32	LANDSCAPING	2002	564		20	28	28	28	32
33	AC OUTLET REPAIRS	2002	880		20	44	44	44	33
34	TOTAL (lines 1 thru 33)		$ 4,039,749	$ 66,422		$ 184,281	$ 117,859	$ 2,522,613	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,039,749	$ 66,422		$ 184,281	$ 117,859	$ 2,522,613	1
2	PARKING LOT LEVELING	2002	850		20	43	43	43	2
3	SINK LINE REPAIRS	2002	635		20	32	32	32	3
4	WIRE REPAIRS	2002	750		20	38	38	38	4
5									5
6									6
7									7
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	1
2									2
3									3
4									4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	1
2									2
3									3
4									4
5									5
6									6
7									7
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,041,984	$ 66,422		$ 184,392	$ 117,970	$ 2,522,724	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	1988	$ 56,408	$ 2,051	35	$ 1,612	$ (439)	$ 41,455	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM MADO MANAGEMENT			1993	21,486	572	20	1,074	502	10,124	9
10	ALLOCATED FROM MADO MANAGEMENT			1995	1,308	261	20	66	(195)	491	10
11	ALLOCATED FROM MADO MANAGEMENT			2000	3,213	-	20	161	161	405	11
12	ALLOCATED FROM MADO MANAGEMENT			2001	1,392	37	20	70	(33)	120	12
13	ALLOCATED FROM MADO MANAGEMENT			2002	3,220	-	20	212	212	212	13
14											14
15											15
16											16
17											17
18											18
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
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43									43
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66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 87,027	$ 2,921		$ 3,195	$ 208	$ 52,807	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 645,889	$ 24,526	$ 26,313	$ 1,787	10	$ 302,621	71
72	Current Year Purchases	9,644	2,785	1,376	(1,409)	10	1,376	72
73	Fully Depreciated Assets	3,100				10	3,100	73
74								74
75	TOTALS	$ 658,633	$ 27,311	$ 27,689	$ 378		$ 307,097	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1995 JEEP LAREDO	1995	$ 25,368	$ 1,775	$	$ (1,775)	5	$ 18,321	76
77										77
78										78
79										79
80	TOTALS			$ 25,368	$ 1,775	$	$ (1,775)		$ 18,321	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,801,235	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 95,508	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,082	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 116,574	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,848,143	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,021 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			93,506			93,506	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				119,368		119,368	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39 - 02					57,175		57,175	12
13	Other (specify): See Supplemental			106,204			259,094		365,298	13
14	TOTAL			$ 106,204		$ 93,506	$ 435,637		$ 635,347	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,011	$ 5,011	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,208,946	1,208,946	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,256	38,256	6
7	Other Prepaid Expenses	183	183	7
8	Accounts Receivable (owners or related parties)	3,817,845	7,452,134	8
9	Other(specify): See Supplemental Schedule	13,870	13,870	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,083,111	$ 8,718,400	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		75,250	13
14	Buildings, at Historical Cost		424,750	14
15	Leasehold Improvements, at Historical Cost	3,487,712	3,495,005	15
16	Equipment, at Historical Cost	184,701	1,165,643	16
17	Accumulated Depreciation (book methods)	(1,711,938)	(4,394,811)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		48,587	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(48,587)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,288,774	22
23	Other(specify): See Supplemental Schedule		17,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,960,475	$ 2,072,550	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,043,586	$ 10,790,950	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,440,450	$ 2,440,451	26
27	Officer's Accounts Payable		1,075,773	27
28	Accounts Payable-Patient Deposits	31,086	31,086	28
29	Short-Term Notes Payable	8,000	2,924,252	29
30	Accrued Salaries Payable	78,808	78,808	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,100	1,100	31
32	Accrued Real Estate Taxes(Sch.IX-B)	251,079	251,079	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,810,523	$ 6,802,549	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,237,762	5,237,762	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,237,762	$ 5,237,762	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,048,285	$ 12,040,311	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,004,699)	$ (1,249,361)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,043,586	$ 10,790,950	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,267,764)	1
2	Restatements (describe):		2
3	EXPENSE RESTATEMENT	144,540	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,123,224)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	118,525	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 118,525	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,004,699)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,741,237	1
2	Discounts and Allowances for all Levels	(240,075)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,501,162	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	696,508	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 696,508	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,131	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	297,594	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	21,606	19
20	Radiology and X-Ray	7,848	20
21	Other Medical Services	225,450	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 553,629	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	547	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 547	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,751,846	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,220,804	31
32	Health Care	3,544,102	32
33	General Administration	1,280,324	33
	B. Capital Expense		
34	Ownership	830,465	34
	C. Ancillary Expense		
35	Special Cost Centers	649,769	35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,633,321	40
41	**Income before Income Taxes (line 30 minus line 40)****	118,525	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 118,525	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,719	3,894	101,353	26.03	3
4	Licensed Practical Nurses	3,330	3,376	56,068	16.61	4
5	Nurse Aides & Orderlies	148,137	158,828	1,084,510	6.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,473	2,570	106,204	41.32	7
8	Rehab/Therapy Aides	2,728	2,834	26,752	9.44	8
9	Activity Director	6,274	6,475	44,216	6.83	9
10	Activity Assistants	12,454	13,221	83,749	6.33	10
11	Social Service Workers	12,402	13,763	126,734	9.21	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	6,237	6,545	76,832	11.74	17
18	Housekeepers	1,685	2,573	26,753	10.40	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,735	6,185	46,132	7.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	205,174	220,264	$ 1,779,303 *	$ 8.08	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	409	$ 9,421	01-03	35
36	Medical Director				36
37	Medical Records Consultant	MONTHLY	4,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	MONTHLY	2,340	10a-03	41
42	Respiratory Therapy Consultant	1,334	43,397	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	114	2,491	11-03	44
45	Social Service Consultant	53	4,474	12-03	45
46	Other(specify)				46
47	DIETARY OUTSIDE LABOR		424,882	01-03	47
48	SOCIAL SERV. OUTSIDE LABOR		29,870	12-03	48
49	TOTAL (lines 35 - 48)	1,910	$ 521,347		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	40,764	$ 1,524,051	10-03	50
51	Licensed Practical Nurses	16,671	318,439	10-03	51
52	Nurse Aides	904	91,980	10-03	52
53	TOTAL (lines 50 - 52)	58,339	$ 1,934,470		53

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - MADO MANAGEMENT	$ 660,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 660,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 14,724
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	2,415
RENITH VILORIA	ACCOUNTING	569
WOLF & CO	ACCOUNTING	3,417
PATRICIA K. HOGAN	LEGAL	501
COMMONWEALTH CLAIMS	INSURANCE SERVICES	171
HEALTH DATA SYSTEMS	DATE PROCESSING	8,333
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 30,130

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 21,101
Unemployment Compensation Insurance	54,776
FICA Taxes	107,857
Employee Health Insurance	
Employee Meals	53,363
Illinois Municipal Retirement Fund (IMRF)*	
401K	595
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,692

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	10,409
Health Care Worker Background Check	2,644
(Indicate # of checks performed 253)	
LICENSES AND DUES	3,892
ALLOC. MADO MANAGEMENT	1,322
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 18,667

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,585
ALLOC. MADO MGMT	167
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,752

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **69,781** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,857**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **53,363** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% ln14**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees